THE MONTANA MEDICAID PROGRAM

State Fiscal Years 2005/2006
Report for the 2007 Legislature

A report by the Montana Department
of Public Health and Human Services

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO Box 4210
HELENA, MT 59604-4210

December 2006

TO: 2007 Legislature

FROM: John Chappuis
State Medicaid Director

On behalf of the Department of Public Health and Human Services, I am pleased to transmit the Montana Medicaid Program Report to the 2007 Legislature.

The Report is comprised of two sections, with the first section summarizing the Montana Medicaid Program mission and the activity for SFY 2005. The second section of the Report beginning on page 26 is intended to address the statutorily required Biennial reporting to the Legislature as contained in 53-6-110, MCA.

As you review the first section it outlines such Medicaid matters as the SFY 2005 eligibility criteria for mandatory and optional populations; the actual enrollment of and benefits paid to the separate eligible populations; enrollment and expenditures by County; Waivers by populations; the number of participating providers and claims they submitted; and the rate setting process are summarized.

The second section details historic and future Federal Medicaid matching rates; SFY 2005 expenditures by eligible populations, by provider type, by cost per service; a 10 year history of expenditures and enrollment; a 10 year comparison of the growth in Montana Medicaid compared to the Health Care Price Index and the Consumer Price Index; cost containment measures; a chronology of major events in Montana Medicaid and finally on page 45 our Medicaid expenditure projections for the 2009 Biennium.

We trust you will find the information contained in the Report useful and if you have any questions or if we can provide additional information please feel free to contact either myself or the Division Administrators' at the phone numbers listed on page 3 of the Report.

Contents:

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program.

Program Mission:

To assure that necessary medical care is available to all eligible Montanans within available funding resources.

Basic Objectives:

•To promote the maintenance of good health by Medicaid eligible persons

•To assure that Medicaid eligible persons have access to necessary medical care

•To assure that the quality of care meets acceptable standards

•To promote the appropriate use of services by Medicaid eligible persons

•To assure that services are provided in the most cost effective manner

•To assure that only medically necessary care is provided

•To assure that the Medicaid program is operated within legislative appropriation

•To assure that prompt and accurate payments are made to providers

•To assure that accurate Medicaid program and financial information is available for management on a timely basis

•To assure that confidentiality and privacy of client information is maintained at all times

•To promote the appropriate utilization of preventive services

MEDICAID PROGRAM MANAGEMENT:

John Chappuis **DPHHS Deputy Director** **Medicaid Director** **444-4084**	
Mary Dalton **Administrator** **Health Resources** **444-4458**	Joe Mathews **Administrator** **Disability Services** **444-2590**
Joyce DeCunzo **Administrator** **Addictive & Mental Disorders** **444-3969**	Shirley K. Brown **Administrator** **Child & Family Services** **444-5900**
Kelly Williams **Administrator** **Senior & Long Term Care** **444-4147**	Jeff Buska **Administrator** **Quality Assurance Division** **444-5401**
Hank Hudson **Administrator** **Human & Community Services** **444-5901**	Jane Smilie **Administrator** **Public Health & Safety** **444-4141**

PROGRAM MANAGEMENT RELATIONSHIP TO MEDICAID:

JOHN CHAPPUIS, DEPUTY DIRECTOR, STATE MEDICAID DIRECTOR
- oversight of all Medicaid programs for State of Montana

MARY DALTON, ADMINISTRATOR, HEALTH RESOURCES DIVISION
- hospital services (inpatient and outpatient)
- physician and mid-level practitioner services
- managed care PASSPORT Program, Nurse First, Team Care and Disease Management
- mental health services for children
- dental services
- (non-physician) licensed provider services (e.g. optometrist, therapists, audiologist, etc)
- Indian Health Service facilities
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- ambulance and transportation services
- pharmacy services
- school-based services
- durable medical equipment

JOE MATHEWS, ADMINISTRATOR, DISABILITY SERVICES DIVISION
- waivers for persons with Developmental disability
- targeted case management services for persons ages 16+ with Developmental disability
- Montana Development Center (facility for persons with developmental disability)

JOYCE DECUNZO, ADMINISTRATOR, ADDICTIVE & MENTAL DISORDERS DIVISION
- mental health services for adults
- chemical dependency treatment
- inpatient psychiatric hospital services
- inpatient psychiatric nursing home services

SHIRLEY K. BROWN, ADMINISTRATOR, CHIILD & FAMILY SERVICES DIVISION
- targeted case management services for children at risk of abuse and neglect

KELLY WILLIAMS, ADMINISTRATOR, SENIOR & LONG TERM CARE DIVISION
- long term care services in the community
- home & community based waiver for adults and physically disabled individuals
- nursing facility services, including Montana Veteran's Home

JEFF BUSKA, ADMINISTRATOR, QUALITY ASSURANCE DIVISION
- facility licensing
- fraud and program compliance
- surveillance utilization & review
- third party liability

HANK HUDSON, ADMINISTRATOR, HUMAN & COMMUNITY SERVICES DIVISION
- Medicaid eligibility

JANE SMILIE, ADMINISTRATOR, PUBLIC HEALTH & SAFETY DIVISION
- targeted case management services for high risk pregnant women
- breast and cervical cancer screening program for low-income women

MEDICAID PROGRAM OVERVIEW:

The Montana Medicaid program is a joint federal-state program that pays for a broad range of medically necessary health care and long-term care services for certain low income populations. The State administers the program in a partnership with the federal Centers for Medicare and Medicaid Services (CMS). The State is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. The Medicaid benefits package is broad and flexible and may range from preventive services to long-term care. The Montana Medicaid program has flexibility with CMS to: 1) design our own benefits package subject to certain minimum requirements and 2) determine provider reimbursement rates based on approved methodologies.

Medicaid services are funded by a combination of federal and state (and in some situations, local) funds. In Montana, the matching rate is approximately 70% federal and 30% state funds. Simply stated, if DPHHS receives 30 cents in general funds, the 30 cents becomes a Medicaid dollar. Some Medicaid services receive an enhanced federal match rate such as services provided in Indian Health Service Facilities at 100%; for family planning services at 90%; and services through the breast and cervical cancer program at 79%. In addition, administrative costs of the State are matched at 50% and data systems are matched at 75%.

Medicaid benefits are a defining element of an individual's eligibility. Federal law requires individuals eligible for Medicaid are entitled to the following services unless waived under Section 1115 of the Social Security Act. These are referred to as mandatory services and include:

- Physician & Nurse Practitioner
- Nurse Midwife
- Medical & Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers
- Rural Health Clinics
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Facility
- Home Health
- Durable Medical Equipment

States may elect to cover other optional services. Montana has chosen to cover a number of cost-effective optional services including, but not limited to, the following:

- Outpatient Drugs
- Dental and Denturist Services
- Comprehensive Mental Health Services
- Ambulance
- Physical & Occupational Therapies and Speech Language Pathology
- Transportation & Per Diem
- Home & Community Based Services
- Eyeglasses & Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry

Indian Health Service (IHS) Facility: The Montana Medicaid Program provides reimbursement for covered medical services to Medicaid-eligible Native Americans who receive those services through an Indian Health Service (IHS) facility or other approved tribal provider. By law, the Medicaid program acts as the "pass through" agency for these services that are funded with 100% federal funds. Medicaid reimburses outpatient IHS services on an all-inclusive, encounter basis and pays for inpatient services using a per diem payment.

Reimbursed expenditures to IHS facilities:

State Fiscal Year	**Expenditures**
2004 (7-1-03---6-30-04)	$25,897,307
2005 (7-1-04---6-30-05)	$30,701,067
2006 (7-1-05---6-30-06)**	$29,061,093

**SFY 2006 figures reflect claims submitted by August 2006. Providers may submit claims 365 days from the date of service and not all claims may have been submitted and paid for SFY 2006.

The Department contracts with the IHS to provide services at the following eleven locations in Montana: Browning, Crow Agency, Harlem, Lodge Grass, Poplar, Hays, Heart Butte, Pryor, Lame Deer, St. Ignatius, and Wolf Point. The facilities at Browning, Crow Agency, and Harlem provide both inpatient and outpatient services. All other facilities provide only outpatient services. The Department also contracts separately for services at the Rocky Boy reservation since they are a self-governing tribal entity. The Indian Health Board of Billings, the Helena Indian Alliance, the Native American Center of Great Falls and the North American Indian Alliance of Butte operate and are paid as Federally Qualified Health Care Center's.

ELIGIBILITY

Although State participation in Medicaid is optional, any State that has Medicaid programs must provide coverage to certain groups or "categories" of people – referred to as categorically eligible. These mandatory groups are described below.

Mandatory Populations:

Families with Dependent Children
Families whose income and resources are below the Family Related Medicaid limits may receive Medicaid. The eligibility for Medicaid is determined separately from TANF.

Pregnant Women
Low-income pregnant women are eligible for Medicaid if their family income is less than 133% of the Federal Poverty Level (FPL), and their resources do not exceed $3,000 (chart for 133% of FPL is in the children eligibility section on the following page).

- Premature babies and medically involved babies are often extremely costly in terms of direct medical expenses. The average estimated cost to Medicaid for a high-risk infant is $53,500 for the first year. High-risk infants are defined as newborns in the hospital for more than 10 days after the time of birth.

- Pregnancy is expensive: $13,500 is the average cost to Medicaid for prenatal care, delivery and newborn pediatric care – compared to $326 per person per year for family planning services.

- In Montana during State Fiscal Year 2004 (July 1, 2003 through June 30, 2004), over 36 percent of childbirths were paid for through Medicaid.

Children
Medicaid is the largest provider of health coverage for children in the State of Montana. During State Fiscal Year 2005 the average number of children enrolled each month was 46,900. Children are eligible for Medicaid if their family's countable resources do not exceed $15,000 (as of July 1, 2006) and if the family meets other financial and non-financial criteria. Eligibility differs by age group.

- Children in Subsidized Adoption or Foster Care
  Any child eligible for an adoption subsidy through the Department, Child and Family Services Division, is automatically eligible for Medicaid. Any child placed by the Department's Child and Family Services Division into licensed foster care is eligible for Medicaid.

- Infants and Children through Age 5
  These children are provided with full coverage under the Medicaid program if family income is less than 133% of the Federal Poverty Level (FPL).

• Children Ages 6 through 18

Children ages 6 through 18 are covered if family income is not greater than 100% FPL. Federal OBRA 89 required states to implement minimum coverage for children ages 6 through 18 at 100% of the FPL.

2005 Federal Poverty Level Gross Monthly Income		
Family Size	100% FPL	133% FPL
1	$798	$1,061
2	$1,069	$1,422
3	$1,341	$1,784
4	$1,613	$2,145
5	$1,884	$2,506
6	$2,156	$2,867
7	$2,428	$3,229
8	$2,699	$3,590
Over 8 add for each person	$272	$362

Early and Periodic Screening, Diagnostic and Treatment Benefit

Early and periodic screening, diagnostic and treatment services (EPSDT) are a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

A Comprehensive Child Health Program --The EPSDT program consists of two, mutually supportive, operational components: 1) assuring the availability and accessibility of required health care resources and 2) helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:

- Seek out eligible individuals and inform them of the benefits of prevention and the health services and assistance available,
- Help them use health resources effectively and efficiently,
- Assess the child's health needs through initial and periodic examinations and evaluation, and
- Assure that health problems found are diagnosed and treated early before they become more complex and their treatment more costly.

States have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within its jurisdiction (as long as the state stays within the federally established framework, standards and requirements).

Under the EPSDT benefit States must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. States must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with established periodicity schedules for these services. Additionally, the Act requires that any service which States are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in the State Medicaid plan.

The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under the EPSDT program are not required to be provided to other program eligible individuals or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

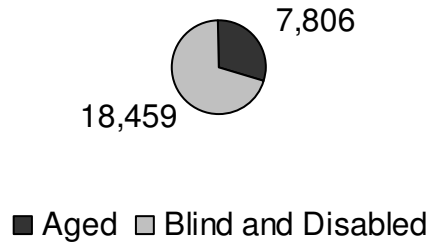
People Who Are Aged, Blind, or Disabled and Receiving Supplemental Security Income (SSI)

Low income aged and disabled persons make up a large group within the Medicaid program. Many aged, blind, and disabled clients live alone and struggle to maintain independence despite health conditions requiring regular medical attention. Medicaid is critical to maintaining their access to medical care and thereby supports a higher level of independence, often reducing the need for more costly medical and support services.

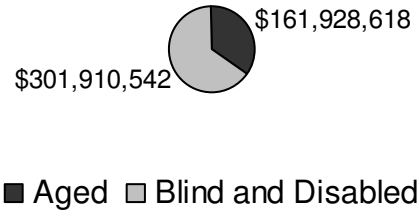
Persons who are aged, blind, or disabled and whose income and resources are below federal Supplemental Security Income (SSI) limits may receive both SSI cash benefits and Medicaid, or they may receive Medicaid only. The Department's Disability Determination Bureau determines disability status for the SSI program. Aged, blind, or disabled persons with income above the SSI standards may be eligible for Medicaid under the medically needy program.

2005		
Family Size	Resource Limit	Monthly SSI Income Limit
1	$2,000	$579
2	$3,000	$869

2005 AVG Monthly Enrollment



Fiscal Year 2005 Expenditures



Optional Populations:

Transitional Medicaid:
Under certain conditions, families are eligible for up to 12 months of extended Medicaid coverage after their eligibility for Section 1931 Medicaid coverage ends due to new or increased earned income. The first six months of this coverage, called Transitional Medicaid, is not dependent on income. To remain eligible in the final six months, the family income must be less than or equal to 185% of the federal poverty level. The family must meet all other eligibility criteria for the entire 12 months.

Family Size	Monthly Income limit-Transitional SFY 2005
1	$1,476
2	$1,978
3	$2,481
4	$2,984
5	$3,485
6	$3,989
7	$4,492
8	$4,993
9	$5,496

Breast or Cervical Cancer
The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment group effective July 1, 2001. Low income uninsured women who are screened through the National Breast and Cervical Cancer Early Detection Program and are diagnosed with breast and/or cervical cancer or pre-cancer receive Basic Medicaid coverage.

To qualify, the woman must be age 64 or younger, have countable income less than or equal to 200% of the Federal Poverty Level, not be eligible for any other category of Medicaid, and not have creditable coverage. There is no resource limit for this program.

Medically Needy
Medically Needy is a federally matched Medicaid program for persons whose resources are less than $2,000 for an individual (or $3000 for a couple/family) and whose monthly income is more than the relevant categorically needy or income limit. The family-related medically needy program is not tied to the SSI limit. This is a federal optional program that the Montana Legislature has chosen to implement.

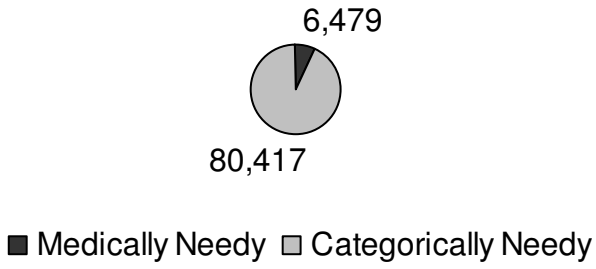
Individuals with income above the Categorically Needy program limits are considered Medically Needy and responsible each month for their medical bills until they have incurred enough medical expenses equal to the difference between their countable income and the medically

needy income level. Individuals may be Medicaid eligible the first of the month by paying this same amount directly to DPHHS. The individual's "spenddown" amount – the monthly amount the individual must incur before Medicaid coverage applies – is based on income. Medicaid eligibility begins at the end of the spenddown period and continues through the end of the month.

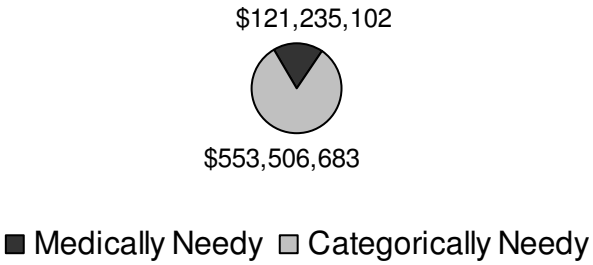
State Fiscal Year 2005 Limits for Medically Needy

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000**	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
7	$3,000	$1,192
8	$3,000	$1,317
9	$3,000	$1,383
10	$3,000	$1,450
**$2,000 for aged, blind, or disabled individuals, $3,000 for family-related programs and for aged, blind, or disabled couples.		

2005 AVG Monthly Enrollment



Fiscal Year 2005 Expenditures



STATE FISCAL YEAR 2005 DATA

Summary of Medicaid Enrolled persons for State Fiscal Year 2005 (July 1, 2004 – June 30, 2005)

	Average Monthly Enrollment						
Beneficiary Characteristic	**All**	**Aged**	**Blind & Disabled**	**Adults**	**Children**	**% of Medicaid Total**	**% of Montana Population**
Total	86,896	7,806	18,459	13,639	46,992	100%	
Age							
5 and Younger	21,955	-	572	-	21,383	25%	8%
6 to 19	27,733	-	2,124	-	25,609	32%	19%
20 to 64	28,559	24	14,899	13,636	-	33%	59%
Over 65	8,649	7,782	864	3	-	10%	14%
Gender							
Male	37,436	1,984	8,892	3,218	23,342	43%	49%
Female	49,460	5,822	9,567	10,421	23,650	57%	51%
Race							
White	61,717	7,007	15,295	8,594	30,821	71%	93%
Native American	21,415	661	2,692	4,545	13,517	25%	5%
Other	3,764	138	472	500	2,654	4%	2%
Assistance Status*							
Medically Needy	6,479	4,201	1,975	10	293	7%	
Categorically Needy	80,417	3,605	16,484	13,629	46,699	93%	
Medicare Status							
Part A and B	15,661	7,697	7,928	36	-	18%	
Part A only	108	22	74	12	-	0%	
Part B only	71	33	38	-	-	0%	
None	71,056	54	10,419	13,591	46,992	82%	

* Categorically Needy persons are those eligible for Medicaid services. Individuals with income above the Categorically Needy program limits are considered Medically Needy and responsible each month for their medical bills until they have incurred enough medical expenses equal to the differences between their countable income and the Medically Needy income level.

As indicated above Medicaid provides services to a disproportionately high percentage of women, children and Native Americans.

Enrollment and Expenditures by County-SFY 2005

County	Population as of July 1, 2005	AVG Medicaid Enrollment	% on Medicaid	Rank by % on Medicaid	Expenditures	AVG Expenditure per Enrollee	Rank by AVG Expenditure per Enrollee
Beaverhead	8,773	718	8%	27	$ 5,822,910	$ 8,110	31
Big Horn	13,149	2,564	19%	3	$ 15,167,745	$ 5,916	49
Blaine	6,629	1,184	18%	4	$ 7,400,975	$ 6,251	48
Broadwater	4,517	377	8%	25	$ 2,548,734	$ 6,761	41
Carbon	9,902	504	5%	45	$ 4,285,427	$ 8,503	24
Carter	1,320	44	3%	53	$ 705,653	$ 16,038	4
Cascade	79,569	7,682	10%	20	$ 58,693,430	$ 7,640	32
Chouteau	5,463	254	5%	50	$ 3,410,829	$ 13,428	7
Custer	11,267	1,245	11%	17	$ 14,161,406	$ 11,375	11
Daniels	1,836	94	5%	43	$ 861,104	$ 9,161	20
Dawson	8,688	586	7%	36	$ 5,819,556	$ 9,931	15
Deer Lodge	8,948	1,062	12%	12	$ 10,164,368	$ 9,571	18
Fallon	2,717	137	5%	46	$ 1,763,595	$ 12,873	10
Fergus	11,551	1,009	9%	22	$ 10,573,888	$ 10,480	14
Flathead	83,172	6,762	8%	29	$ 48,388,623	$ 7,156	37
Gallatin	78,210	3,130	4%	52	$ 22,321,956	$ 7,132	38
Garfield	1,199	59	5%	47	$ 511,235	$ 8,665	21
Glacier	13,552	3,778	28%	2	$ 22,048,713	$ 5,836	50
Golden Valley	1,159	109	9%	23	$ 397,891	$ 3,650	54
Granite	2,965	190	6%	38	$ 1,257,957	$ 6,621	43
Hill	16,304	2,509	15%	8	$ 16,518,861	$ 6,584	44
Jefferson	11,170	682	6%	40	$ 18,949,639	$ 27,785	1
Judith Basin	2,198	170	8%	30	$ 487,169	$ 2,866	56
Lake	28,297	3,717	13%	9	$ 24,135,029	$ 6,493	46
Lewis & Clark	58,449	4,768	8%	28	$ 41,305,193	$ 8,663	22
Liberty	2,003	59	3%	55	$ 761,525	$ 12,907	9
Lincoln	19,193	2,317	12%	11	$ 15,187,508	$ 6,555	45
McCone	1,805	298	17%	6	$ 2,852,568	$ 9,572	17
Madison	7,274	71	1%	56	$ 1,149,182	$ 16,186	3
Meagher	1,999	137	7%	35	$ 1,116,186	$ 8,147	28
Mineral	4,014	634	16%	7	$ 3,336,589	$ 5,263	52
Missoula	100,086	8,368	8%	24	$ 68,839,214	$ 8,226	25
Musselshell	4,497	474	11%	18	$ 3,150,214	$ 6,646	42
Park	15,968	968	6%	41	$ 7,872,136	$ 8,132	29

County	Population as of July 1, 2005	AVG Medicaid Enrollment	% on Medicaid	Rank by % on Medicaid	Expenditures	AVG Expenditure per Recipient	Rank by AVG Expenditure per Recipient
Petroleum	470	24	5%	44	$ 177,995	$ 7,416	35
Phillips	4,179	494	12%	14	$ 3,673,915	$ 7,437	34
Pondera	6,087	788	13%	10	$ 5,573,514	$ 7,073	39
Powder River	1,705	75	4%	51	$ 1,129,759	$ 15,063	5
Powell	6,999	500	7%	34	$ 4,728,114	$ 9,456	19
Prairie	1,105	79	7%	33	$ 890,331	$ 11,270	12
Ravalli	39,940	2,869	7%	31	$ 20,288,671	$ 7,072	40
Richland	9,096	745	8%	26	$ 7,383,020	$ 9,910	16
Roosevelt	10,524	3,148	30%	1	$ 15,925,720	$ 5,059	53
Rosebud	9,212	1,638	18%	5	$ 9,012,220	$ 5,502	51
Sanders	11,057	1,109	10%	19	$ 7,086,329	$ 6,390	47
Sheridan	3,524	224	6%	39	$ 3,242,332	$ 14,475	6
Silver Bow	32,982	3,905	12%	13	$ 32,098,868	$ 8,220	26
Stillwater	8,493	400	5%	49	$ 2,953,232	$ 7,383	36
Sweet Grass	3,672	119	3%	54	$ 1,592,996	$ 13,387	8
Teton	6,240	297	5%	48	$ 3,296,252	$ 11,098	13
Toole	5,031	328	7%	37	$ 2,684,651	$ 8,185	27
Treasure	689	40	6%	42	$ 142,926	$ 3,573	55
Valley	7,143	817	11%	15	$ 6,948,054	$ 8,504	23
Wheatland	2,037	229	11%	16	$ 1,731,973	$ 7,563	33
Wibaux	951	68	7%	32	$ 1,364,945	$ 20,073	2
Yellowstone	136,691	12,260	9%	21	$ 99,573,044	$ 8,122	30
Other/Institutions		80			$ 1,275,917	$ 15,949	
Montana	**935,670**	**86,896**	**9%**		**$ 674,741,785**	**$ 7,765**	

Population estimates as of July 1, 2005 were sourced from the Census & Economic Information Center, Montana Department of Commerce.

The enrollment and expenditure data excludes CHIP and State Fund Mental Health.

MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

The Addictive and Mental Disorders Division (AMDD) provided Medicaid funded mental health services to 13,586 adults in SFY 2005. This represents an increase of approximately 4% over the SFY 2003 recipient caseload.

The mental health program provides a full array of outpatient and inpatient services to adults and youth suffering from mental illnesses through a fee-for-service system with Montana community providers. The community providers deliver services such as therapies, adult foster and group care, day treatment, rehabilitation and support, care coordination and case management services. The program provides inpatient and outpatient hospital services and out-of-home care services including residential treatment, therapeutic foster and group care.

To deliver the variety of services, the program utilizes the services of licensed professional counselors, physicians, hospitals, psychologists, psychiatrists, social workers, mental health centers, mid level practitioners, and out-of-home providers for group care and residential treatment.

AMDD's chemical dependency program provides a full array of outpatient and inpatient services to youth, and outpatient services to adults through a fee-for-service system with Montana community providers. Community providers consist of 7 inpatient free standing residential treatment providers and 23 outpatient service providers. The community providers deliver services such as assessment, individual and group therapies, family and family group therapies, and case management (liaison services) for youth and adults. Community providers deliver free-standing residential day treatment and free-standing inpatient 24 hour – 7 day a week service for youth.

To deliver the variety of services, the program utilizes the services of state-approved substance dependency and abuse treatment programs under contract with the Division's Chemical Dependency Bureau. The primary professional involved in the service delivery within these providers is a licensed addiction counselor. Inpatient and day treatment service requires prior written approval from the Chemical Dependency Bureau as well as continue care reviews.

WAIVERS

General Description: WAIVERS
State Medicaid programs may waive certain requirements, such as statewideness, freedom of choice, or comparability.

- States may *pay for medical care in the home* for persons who would otherwise be eligible (due to the income and resources of a spouse or parent) only in an institutional setting. This is important for families facing institutionalizing a child or family member in order to receive assistance with the medical costs.
- States may *target services to particular groups*, such as elderly individuals, technology-dependent children, individuals with traumatic brain injuries, or persons with mental retardation or developmental disabilities.

Section 1115 waivers of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary,(are) likely to assist in promoting the objectives of (the Medicaid statute).

1115 waivers allow flexibility, which is sufficiently broad to allow States to test substantially new ideas of policy merit. States commit to a policy experiment that will be evaluated. Section 1115 should demonstrate something that has not been demonstrated on a widespread basis, the specific research / demonstration findings will be drawn from the projects results.

Section 1915(b) waivers of the Social Security Act provides "the Secretary may . . . waive such requirements of section 1902(other than sections 1902(a) (13)(E) and 1902(a)(10)(A) insofar as it requires provision of care and services described in section 1905(a)(2)(C))."

Section 1915 (b) waivers allow States to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers are limited in that they apply only to existing Medicaid eligible beneficiaries, authority under this waiver cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice Waivers:
(b)(1) mandates Medicaid Enrollment into managed care
(b)(2) utilize a "central broker"
(b)(3) uses cost savings to provide additional services
(b)(4) limits number of providers for services

Section 1915(c) waivers are referred to as the Medicaid Home and Community-Based Services (HCBS) waiver program and are alternatives to providing long-term care in institutional settings. Section 1915(c) of the Act authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements to enable you to cover a broad array of home and community-based services as an alternative to institutionalization.

Waivers for Persons with Developmental Disability (DD)

•The Developmentally Disabled Waiver (0208.90)----------1915(c):
This waiver was initiated in 1981 (one of the first waivers in the country) to provide community based services to persons receiving services in a small program which had been decertified as an Intermediate Care Facility for Mental Retardation (ICF-MR). This waiver has grown in size and scope during the past 24 years. For the period 7/1/04-6/30/05, Medicaid reimbursed $56,320,427 for 1,882 persons with DD in this waiver. Services consist of supports to 344 children (age 0 through 21) with DD and intensive supports needs. The majority of these children live at home.

The remainder of individuals received services under this waiver in SFY05. The vast majority of reimbursement is for group home, supported living, work/day, and transportation services to adults with DD. Other services available under this waiver include the following (which are different in scope, duration or amount from any related state plan services): psychological services, personal care, homemaker, respite, occupational therapy, physical therapy, speech therapy, environmental modifications, nutritional evaluations, private duty nursing, meals and respiratory services. The average cost per person served in this waiver was $29,926 in SFY05 (excluding the cost of any state plan services accessed by the recipient).

•The "Community Supports" Waiver (0371)----------1915(c):
The Community Supports (CS) waiver was approved by the Centers for Medicare and Medicaid Services in 2001. This waiver served 262 adults (age 18 years and up) with developmental disabilities for the period 7/1/04-6/30/05, expending $1,637,905 in Medicaid funds. The average cost per person was $6,252, thus it is considered a relatively low cost service option. Many persons in the Community Supports waiver live at home, so supports are often purchased to help unpaid primary care givers better meet the needs of an adult family member with DD. Services available in the Community Supports waiver include: homemaker, personal care, respite, residential habilitation, day habilitation, prevocational training, supported employment, environmental modifications, transportation, specialized medical and adaptive equipment, adult companion, private duty nursing, social/leisure/recreation opportunities, health/safety supports and educational services.

Senior Long Term Care (SLTC) Waiver

•Home and Community Based Services – SLTC----------1915(c):

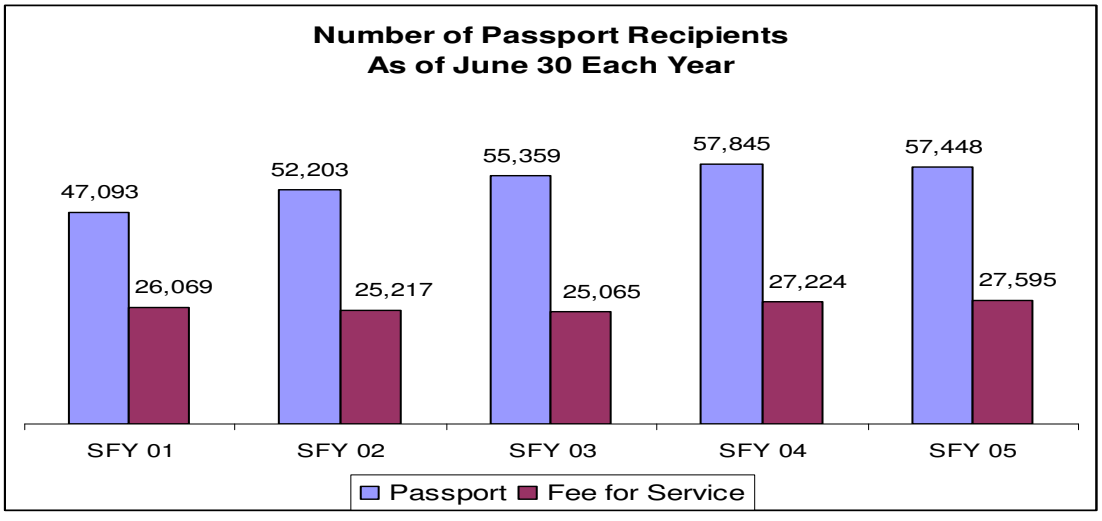
Home and Community Based Services are individually prescribed and arranged according to the individual needs of the consumer. To be eligible for the Home and Community Based Services Program, individuals must be Medicaid eligible, require the level of care of a nursing facility, and be physically disabled or over 65 years of age. To access the program, there must be funds available, or a slot as it is often referred to. The Department contracts with case management teams to develop an individual plan of care in conjunction with the consumer and attending physician. An individual's total HCBS plan of care costs may not exceed a cost limit set by the Department. This program provides case management, respite, adult residential care, specialized services for those with traumatic brain injuries, environmental modifications, adult day health, and personal emergency response systems, just to name a few. This program is vital to allowing consumers to remain in the community instead of entering an institution.

Medicaid Managed Care----------1915 (b) Waiver

PASSPORT To Health (PASSPORT): is Montana's managed health care program. Under PASSPORT, eligible Medicaid enrollees choose a primary care provider (PCP) who manages their health care. Most services must be provided by the PCP or require the PCP's authorization to be reimbursed by Medicaid. The care management provided by the PCP enhances care while reducing costs by minimizing ineffective or inappropriate medical care to Medicaid recipients. PASSPORT cost avoids over $20 million per year in medical costs and improves quality of care.

Quality of and access to care is continuously monitored, and is consistently equal to or better than Medicaid-funded care to similar non-PASSPORT clients.

Medicaid covered approximately 114,000 different people during State Fiscal Year 2005. Approximately 83,000 of these people were enrolled in the PASSPORT Program. PASSPORT operates in 55 of 56 counties.



Basic Medicaid Waiver for Able-Bodied Adults----------1115

In 1996 under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM), Montana implemented a limited Medicaid benefit package of optional services to the same group of adults eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act (the individuals were age 21 to 64, not pregnant and not disabled). The limited Medicaid benefit package was referred to as "Basic Medicaid". The FAIM welfare reform waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act.

This waiver excludes coverage by Medicaid for certain optional services: audiology and hearing aids, personal assistance services, durable medical equipment, routine eye exams provided by an ophthalmologist or an optometrist, eyeglasses, dental and denturist services. The Department recognizes there may be situations where the excluded services are necessary as in an emergency or medical situation or if essential for employment. Under these defined situations, if the standards and criteria are met, Medicaid may cover the excluded service. Each individual request is evaluated.

Montana Medicaid Covered Services

Services	Categorically Needy– Children	Categorically Needy – Adults	Medically Needy	Family-Related Adults (Basic Medicaid
Ambulance	Yes	Yes	Yes	Yes
Anesthesia	Yes	Yes	Yes	Yes
Audiology	Yes	Yes	Yes	No*
Targeted Case Management	Yes – if in target group	Yes – if in target group	Yes – if in target group	Yes – if in target group
Chemical Dependency	Yes	Yes	Yes	Yes
Chiropractic	Yes	QMB only	QMB only	No
Clinic Services	Yes	Yes	Yes	Yes
Comprehensive Mental Health Services	Yes	Yes	Yes	Yes
Dental Services	Yes	Yes	Yes	No*
Dentures	Yes	Yes	Yes	No*
Prescription Drugs	Yes	Yes	Yes	Yes
Dialysis	Yes	Yes	Yes	No
Durable Medical Equipment	Yes	Yes	Yes	No*
Emergency Rooms	Yes	Yes	Yes	Yes
Eyeglasses/Optician	Yes	Yes	Yes	No*
Family Planning	Yes	Yes	Yes	Yes
Federally Qualified Health	Yes	Yes	Yes	Yes

Services	Categorically Needy– Children	Categorically Needy – Adults	Medically Needy	Family-Related Adults (Basic Medicaid
EPSDT	Yes	No	Children only	No
HCBS Waiver Services	Yes	Yes	Yes	No
Hearing Aids	Yes	Yes	Yes	No*
Home Dialysis Attendant	Yes	Yes	Yes	No
Home Health	Yes;P/A	Yes;P/A	Yes;P/A	Yes;P/A
Hospice	Yes	Yes	Yes	Yes
Inpatient Hospital Care	Yes	Yes	Yes	Yes
Indian Health Service Facility	Yes	Yes	Yes	Yes
Mid-Level Practitioners	Yes	Yes	Yes	Yes
Nursing Facility Services	Yes	Yes	Yes	Yes
Nutrition Therapy	Yes	No; **	Children only; **	No
Occupational Therapy	Yes	Yes	Yes	Yes
Optometric	Yes	Yes	Yes	No*
Organ Transplant	Yes	Limited	Limited for adults	Limited
Out of State Medical Services	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
Outpatient Hospital Care	Yes	Yes	Yes	Yes
Respiratory Services	Yes	No; **	Children only; **	No
Pain management	Yes	Yes	Yes	Yes
Personal Assistance	Yes; P/A	Yes; P/A	Yes; P/A	No
Physical Therapy	Yes	Yes	Yes	Yes
Physician Services	Yes	Yes	Yes	Yes
Podiatry	Yes	Yes	Yes	Yes
Private Duty Nursing	Yes	No; **	No; **	No
Rural Health Clinics	Yes	Yes	Yes	Yes
School Medical Services	Yes	No	Children only	No
Speech therapy	Yes	Yes	Yes	Yes
Transportation	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
X-Ray, Lab and Imaging Services	Yes	Yes	Yes	Yes

* Services may be authorized for certain medical conditions, emergency situations or if essential for employment.

** Home and Community Based Services waiver may include coverage for these services for enrollees.

Medically Needy: See page 12 for eligibility description.

P/A: Prior Authorization is required.

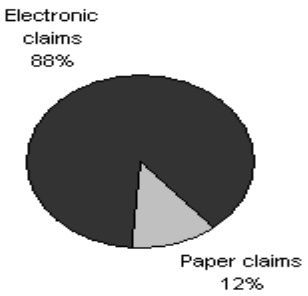
Organ Transplants: Coverage for adults is limited to kidney, cornea, and bone marrow.

PROVIDERS AND CLAIMS PROCESSING

As of August 31, 2006, there are 15,109 providers enrolled as Montana Medicaid providers. As a comparison as of October 31, 2004 there were 12,463 providers enrolled. During SFY 2006, 10,640 providers actively billed Montana Medicaid. Again for comparative purposes during SFY 2004, 8,938 providers actively billed Montana Medicaid. Providers must submit claims to Affiliated Computer Services (ACS) 365 days from the dates of service for the claims to be considered filed timely.

ACS is contracted with the Department of Public Health and Human Services to serve as the fiscal agent, below are statistics on the number of claims submitted and processed in SFY 2006.

	Number processed	% of Total
Paper claims	844,317	12%
Electronic claims	6,015,349	88%
Total claims	6,859,666	100%



In State Fiscal Year 2004 there were 6,667,205 claims submitted and processed of which 1,399,840 (21%) were paper claims and 5,267,365 (79%) were electronic claims. Total claims submitted and processed in SFY 2006 were 2.90% higher than those processed in SFY 2004. The percentage of paper claims submitted and processed in SFY 2006 decreased to 12%, with electronic claims submitted and processed increasing to 88%.

From claim receipt to processing, during SFY 2006, on average it took 5.2 days for ACS to process all claims.

Last year, ACS received 101,802 calls to their call center; 4,259 new providers were enrolled; and 2,087 providers terminated enrollment.

RATE SETTING PROCESS

The Medicaid Program uses several methods to establish payment rates for services:

Fee-for-Service

The Department pays most providers a fee for the service provided. Rates are based on costs or a percentage of charges in accordance with federal regulations. PASSPORT (primary care case management) providers also receive a $3.00 per member per month fee for case management services they provide. In general, provider rates are prospective and payment is final with no settlement back to actual costs.

Reimbursement Systems

Montana Medicaid's reimbursement systems include a Diagnosis Related Groups (DRG) system for inpatient services for some hospitals, Ambulatory Payment Classification (APC) for these same hospitals for outpatient hospital services, cost based reimbursement for hospitals classified as Critical Access Hospitals and Resource Based Relative Value Scale (RBRVS) for physician/professional services. These reimbursement systems use cost, utilization, and other factors – such as measures of relative value or relative acuity – in determining provider payment rates.

Resource Based Relative Value System (RBRVS)

Montana Medicaid reimburses physicians and other providers who bill on CMS-1500 forms with Medicare's resource based relative value system (RBRVS). Reimbursement is based on the value of a service relative to all other services. The calculations compare the resources needed for a specific service (office expenses, malpractice insurance, and provider work effort and complexity) to those needed for other services. Each service code is assigned one or more relative value units (RVU's) designating its position on the relative value scale. This system was developed nationally by Centers for Medicare & Medicaid Services (CMS), the American Medical Association, and non-physician provider associations; it is adjusted annually. Montana receives the benefit of this large, ongoing investment in research and policy-making without yielding control of costs. The fee for each code is determined by multiplying the RVU by a conversion factor with a dollar value. The conversion factor is Montana-specific to insure the overall budget neutrality of the Medicaid appropriation. The conversion factor is adjusted annually based on the Montana Legislature's most recent biennial appropriation.

MONTANA PUBLIC HEALTH CARE REDESIGN PROJECT

The 2003 Legislature adopted HJ 13, which requested that the Department undertake a study that would examine the various options available for redesigning the Montana Medicaid program. The Governor appointed a 20-member advisory council to assist the Department in the redesign project (Public Health Care Advisory Council).

The Department completed in June 2004, a Montana Public Health Care Redesign Project Report, in close collaboration with the Public Health Care Advisory Council, with significant input from the general public, and work by staff of the Department. The Report was provided to the 2005 Legislature outlining options that could be undertaken to redesign the health programs administered by the Department. The redesign project was intended to reframe Montana's Medicaid program in a fashion that was financially sustainable into the future.

There were 18 recommendations resulting from the Redesign Project and they were split into those involving operational changes (actually made and adopted by the Department in advance of June 2004), those involving adjustments or refocusing of existing programs not requiring legislation or changes in funding, and those that required action by the state Legislature and/or the federal government.

The Department adopted seventeen of the recommendations and prepared related legislative and budget requests for presentation to the 2005 Legislative session. In particular the eight recommendations requiring state or federal government action were:

-Improve Services for Seriously Emotionally Disturbed Children;

-Submit a Health Insurance Flexibility and Accountability Waiver (HIFA);

-Initiate Changes in Medicaid Eligibility;

-Seek Tribal Exemption (from eligibility type changes that could result in a direct shift of costs from the 100 percent federal Medicaid reimbursement to direct costs to either Indian Health Services or tribally sponsored health-care services);

-Explore the Implementation of Pharmacy Cost Containment;

-Explore the Feasibility of the Submission of a Family-Planning Waiver;

-Review the Feasibility of Implementing a Pilot Transportation Brokerage System;

-Seek Codifying Legislation when Considering Changes in Policy or Reduction of Services;

Legislative bills that resulted from the above eight recommendations and that were passed by the 2005 Legislature were as follows:

House Bill 183-Authorized the Department to pursue a Medicaid waiver for services to seriously emotionally disturbed children;

House Bill 452-Authorized the Department to pursue a waiver to exempt Indian Health Services providers from Medicaid state plan changes that could reduce reimbursement to tribal service providers;

House Bill 552-Revised the asset test used to determine children's eligibility for the Medicaid program by raising the asset limit from $3,000 to $15,000;

House Bill 667-Provides for purchasing pools, premium assistance and tax credits for small employers providing health insurance;

Senate Bill 41-Implements guiding principles to be used by the Department when it considers budget reductions or increases. Principles specified include protecting those persons who are most vulnerable and most in need; giving preference to the elimination of an entire Medicaid program or service, rather than sacrifice the quality of care for several programs or services through the dilution of funding; giving priority to retaining those services that protect life, alleviate severe pain and prevent significant disability;

Senate Bill 42-Clarifies that the children's system of care and service area authority must take into account each other's recommendations with regard to planning and implementation of children's mental health services;

Senate Bill 110-Allows the Department to seek a Health Insurance Flexibility and Accountability Waiver (HIFA).

Senate Bill 324-Provides for a prescription drug program and prescription drug technical assistance.

EXPENDITURE ANALYSIS

Medicaid services are funded by a combination of federal and state (and in some situations, local funds). The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita income compared to the national average.

The matching rate for Medicaid administration is set at either 50%, 75% or 90% depending on the type of administrative activities and pre-approval from Centers for Medicare & Medicaid Services (CMS).

Most administrative cost fall into the 50% matching rate, however program activities that are related to medical claims processing, MMIS and certain others can be matched at an enhanced rate of either 75% or 90%. Services provided for family planning also receive an enhanced match rate of 90%.

A decrease in the federal matching rate has a negative effect on the total dollars available for funding services.

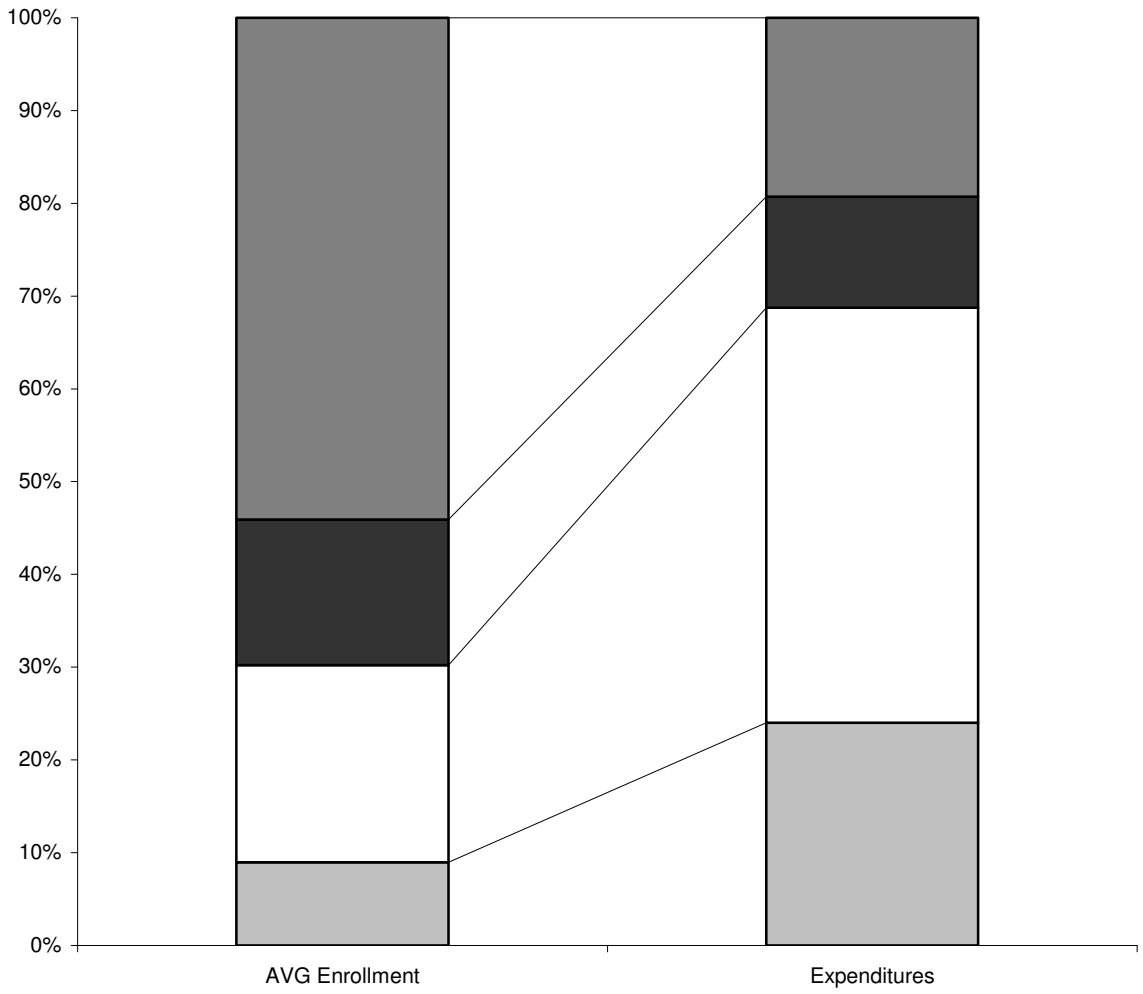
Montana Medicaid Benefits Federal Matching

State Fiscal Year	2000	2001	2002	2003*	2004
Federal Match Rate	72.30%	73.04%	72.83%	74.15%	75.36%
State Funds Percentage	27.70%	26.96%	27.17%	25.85%	24.64%

- Effective April 1, 2003 until June 30, 2004 the Federal matching rate was enhanced by 2.95%.

State Fiscal Year	2005	2006	2007	2008	2009
Federal Match Rate	71.96%	70.66%	69.29%	68.61%	68.51%
State Funds Percentage	28.04%	29.34%	30.71%	31.39%	31.49%

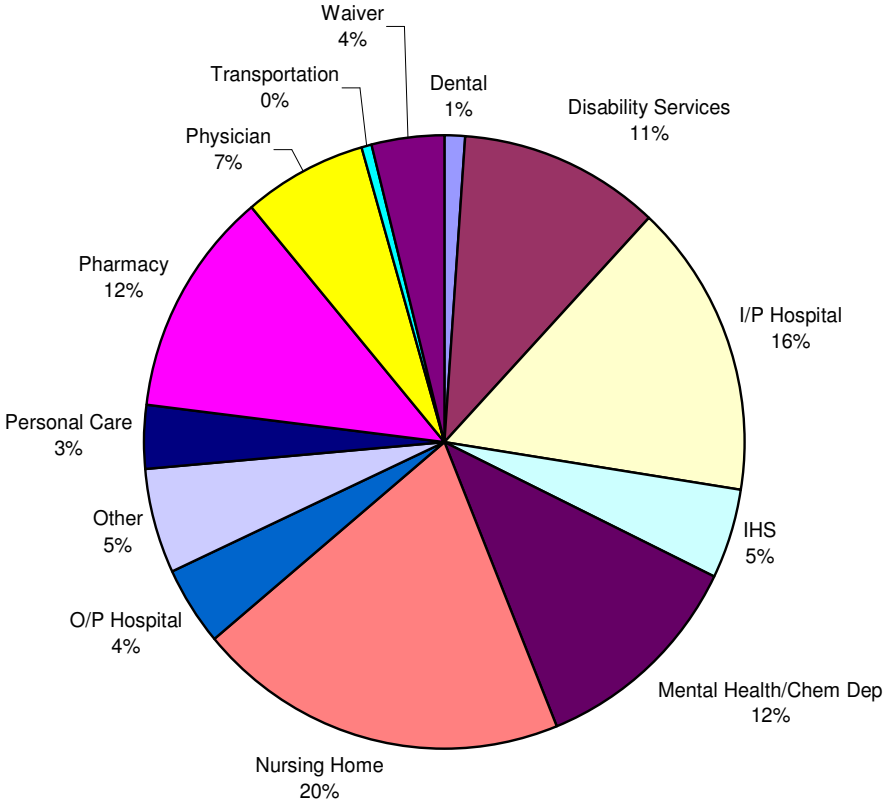
SFY 2005 EXPENDITURES by Major Aid Category



	AVG Enrollment	% of Enrollment		Expenditures	% of Expenditures
Aged	7,806	9%	$	161,928,618	24%
Blind and Disabled	18,459	21%	$	301,910,542	45%
Adults	13,639	16%	$	80,726,075	12%
Children	46,992	54%	$	130,176,550	19%

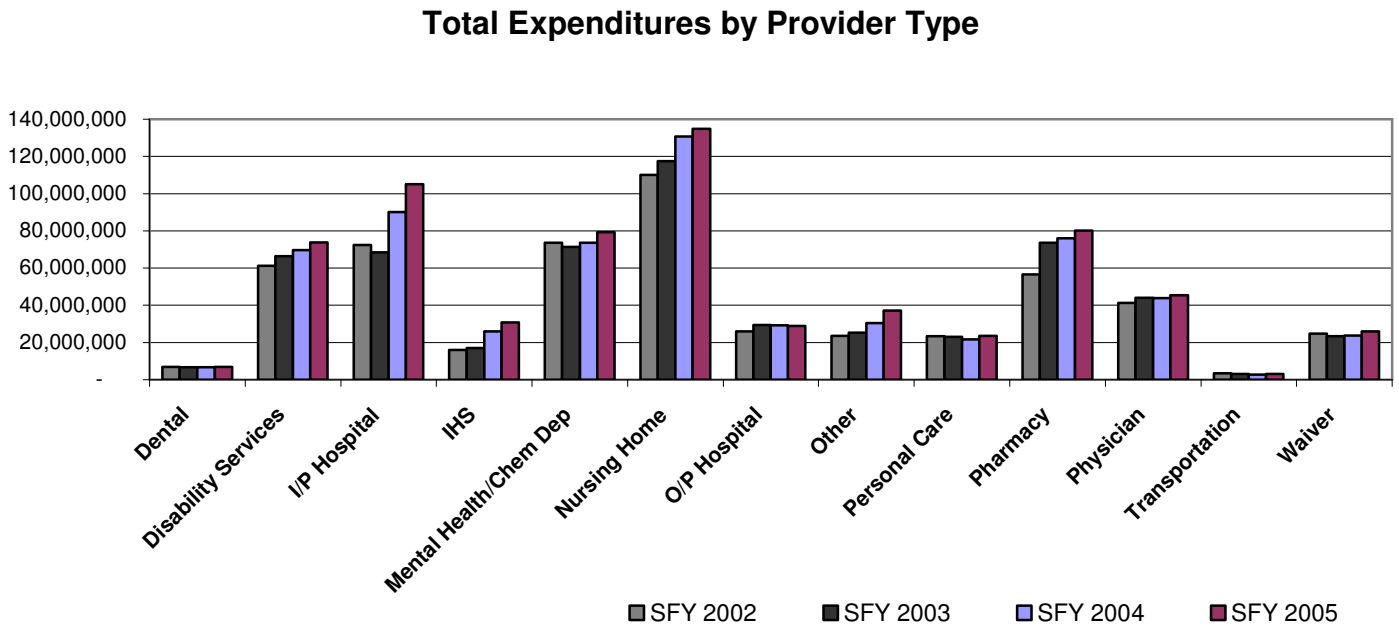
The chart at the left shows Medicaid enrollment in 2005 by aid category. The chart to the right reflects funds expended by aid category. The Aged and Disabled are a relatively small percentage of the entire Medicaid population, but account for a high percentage of the Medicaid funds expended. Conversely, Children represent slightly more than half of the Medicaid population but account for less than one-fifth of the cost.

SFY 2005 EXPENDITURES by Provider Type



Please see the following page for actual SFY 2005 expenditures.

SFY 2002 to 2005 EXPENDITURES by Provider Type

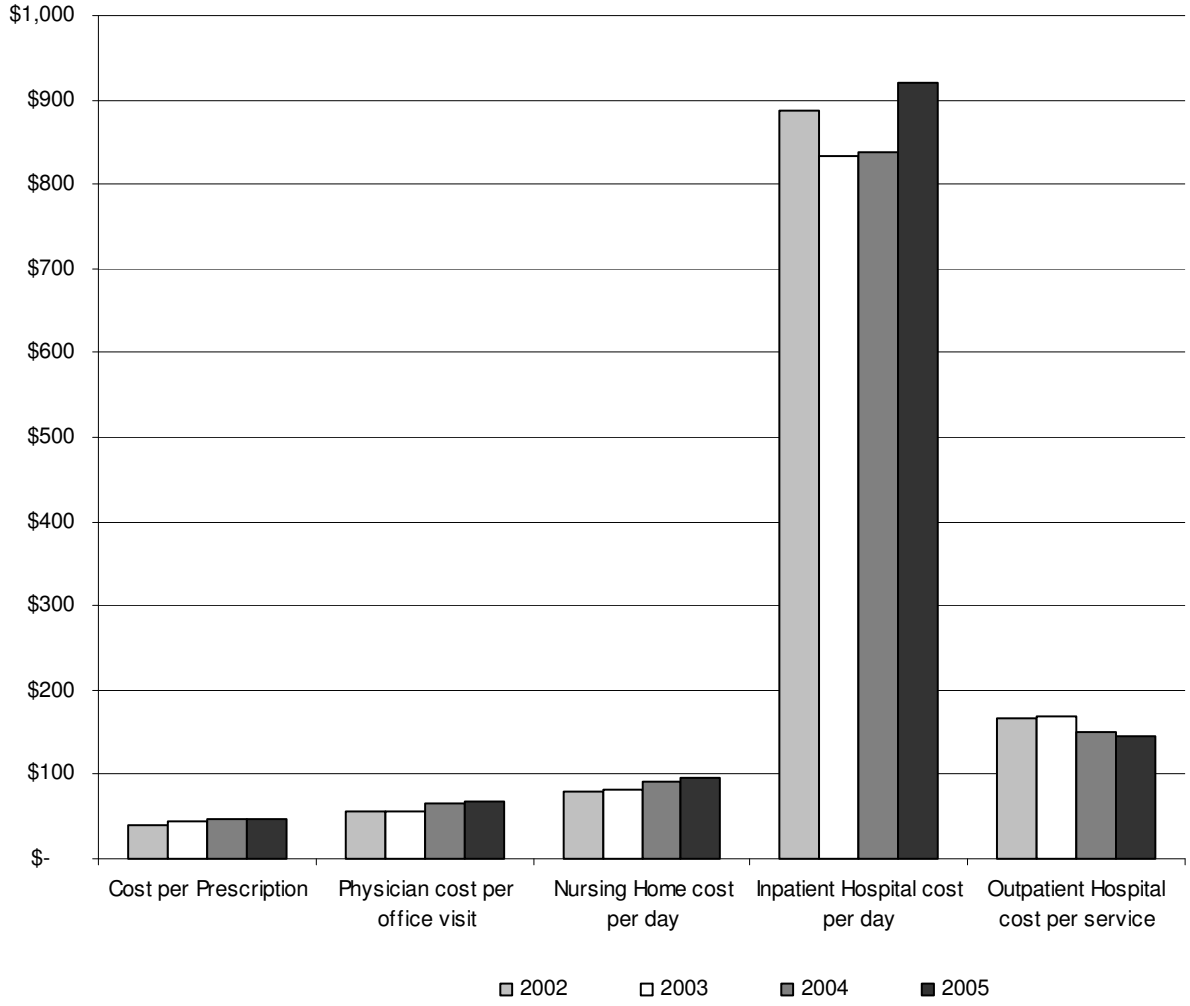


	SFY 2002	SFY 2003	SFY 2004	SFY 2005
Dental	6,807,666	6,657,316	6,647,943	6,961,473
Disability Services	61,284,846	66,420,214	69,704,774	73,853,118
I/P Hospital	72,332,358	68,423,606	90,083,563	105,000,577
IHS	16,000,841	16,949,592	25,897,307	30,701,067
Mental Health/Chem Dep	73,617,290	71,431,106	73,561,663	79,208,913
Nursing Home	110,001,784	117,387,029	130,681,000	134,819,641
O/P Hospital	25,982,987	29,347,636	29,159,522	28,885,395
Other	23,526,817	25,223,479	30,443,834	37,078,444
Personal Care	23,431,095	23,123,157	21,636,577	23,551,534
Pharmacy	56,604,791	73,580,949	76,001,604	80,135,704
Physician	41,307,481	44,039,024	43,772,463	45,437,188
Transportation	3,389,077	3,142,788	2,690,425	3,060,819
Waiver	24,751,756	23,315,381	23,651,739	26,047,912
	539,038,789	569,041,277	623,932,414	674,741,785

Pharmacy expenditures have been reduced by the amount of rebates collected. I/P Hospital expenditures include Hospital Utilization Fees and DSH payments. Nursing Home expenditures include IGT payments. All expenditures are sourced from those recorded on the Montana Medicaid Management Information System (MMIS) and from those benefit related expenditures paid outside of the MMIS.

Cost Per Service

Regardless of the provider type, the cost of service is an average of the various services rendered by the provider. Each year the average cost paid per service is strongly affected by a number of factors including patient acuity, new procedures, supply cost, new technology, and inflation.

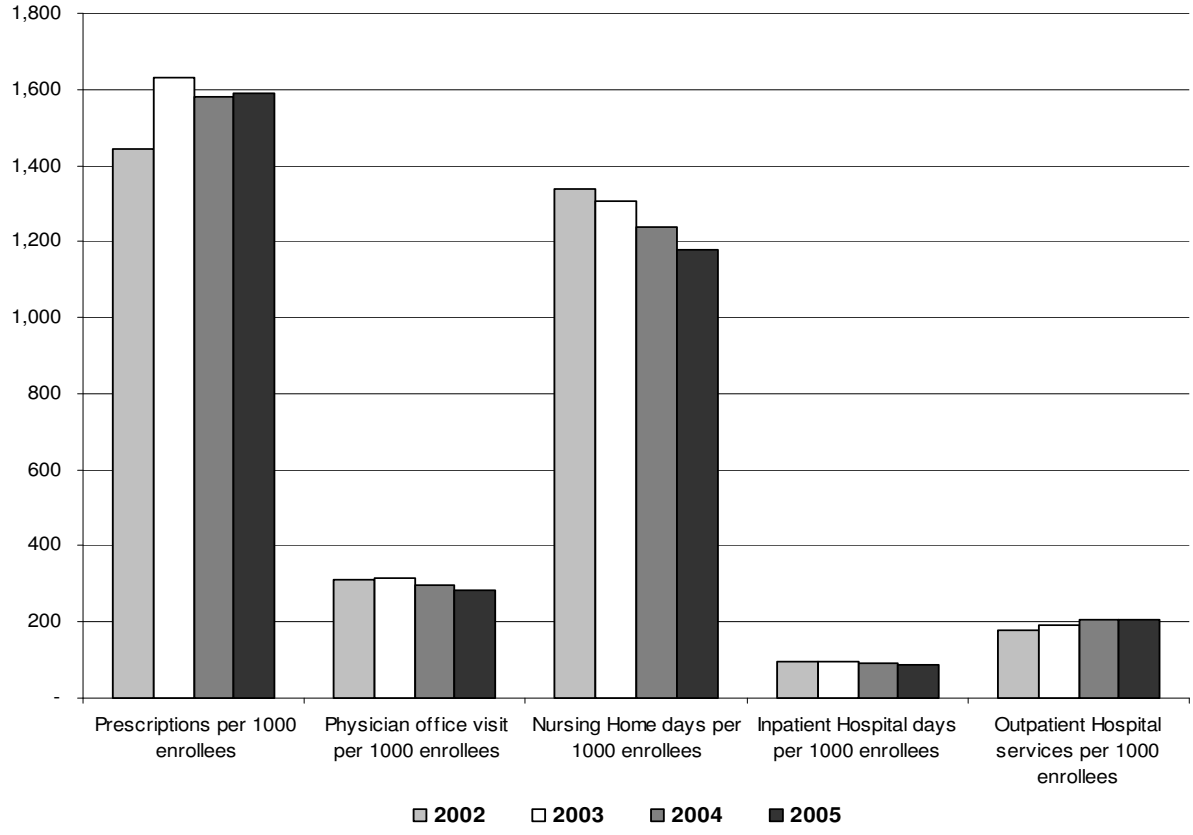


	2002	2003	2004	2005
Cost per Prescription	$ 41	$ 45	$ 47	$ 48
Physician cost per office visit	$ 57	$ 57	$ 66	$ 69
Nursing Home cost per day	$ 79	$ 83	$ 91	$ 97
Inpatient Hospital cost per day	$ 887	$ 833	$ 837	$ 920
Outpatient Hospital cost per service	$ 166	$ 168	$ 151	$ 145

Physician and Hospital services exclude services where Medicare is the primary payor.
Prescription expenditures have been reduced by rebates collected.

Units of Service

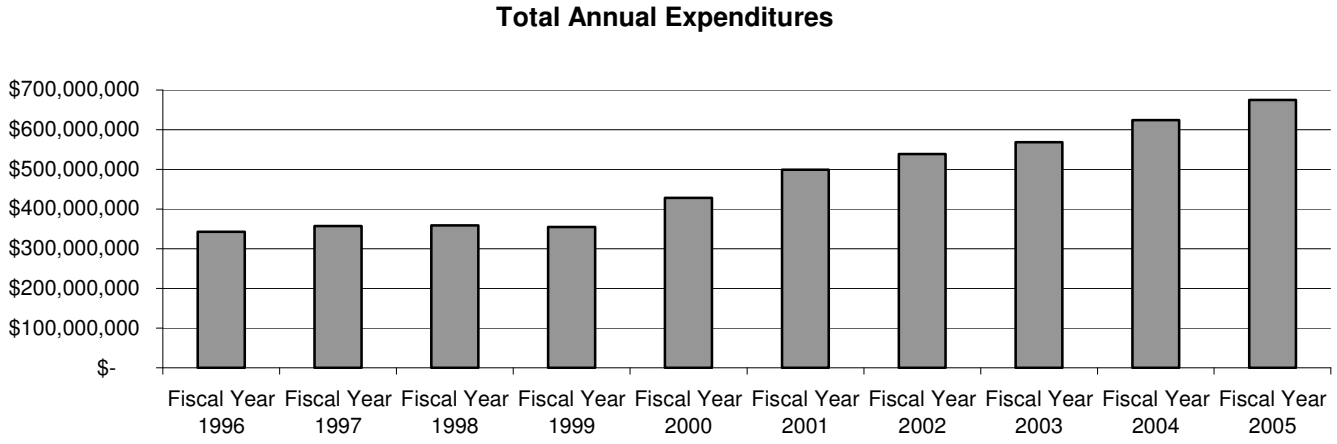
The definition of a unit of service varies greatly both within and between provider types. Medicaid covers approximately 10,000 procedures. These procedures can vary from extreme complexity to procedures as simple as stitching a minor wound. The total units of service is affected each year by a number of factors including patient acuity, technology changes, and changes in treatment protocol.

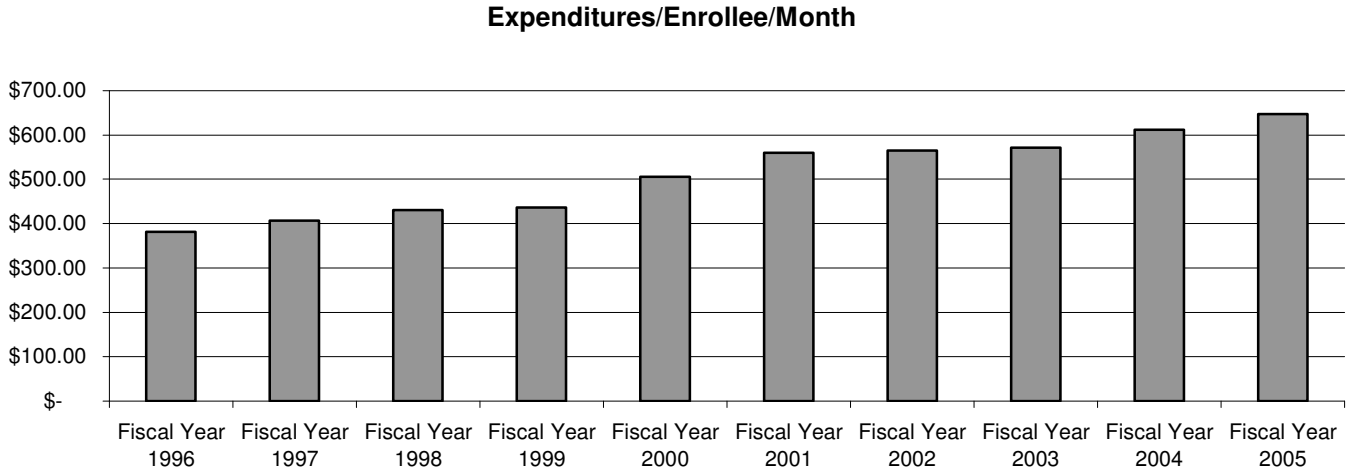


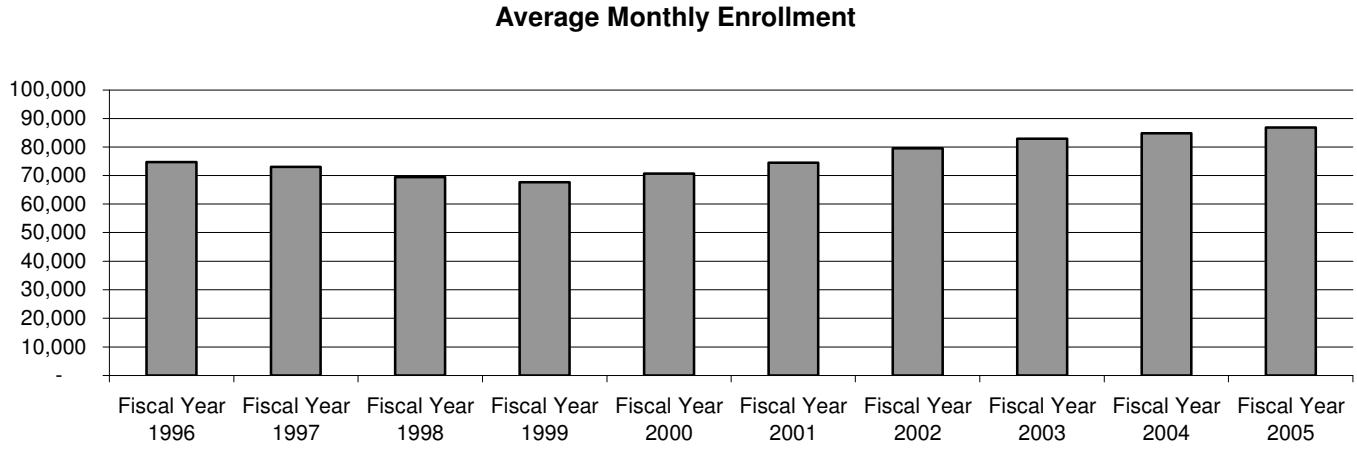
	2002	2003	2004	2005
Prescriptions per 1000 enrollees	1,442	1,632	1,581	1,589
Physician office visit per 1000 enrollees	310	315	297	283
Nursing Home days per 1000 enrollees	1,340	1,308	1,239	1,178
Inpatient Hospital days per 1000 enrollees	97	95	90	89
Outpatient Hospital services per 1000 enrollees	180	194	205	207

Physician and Hospital services exclude services where Medicare is the primary payor.

10 Year History of Expenditures and Enrollment

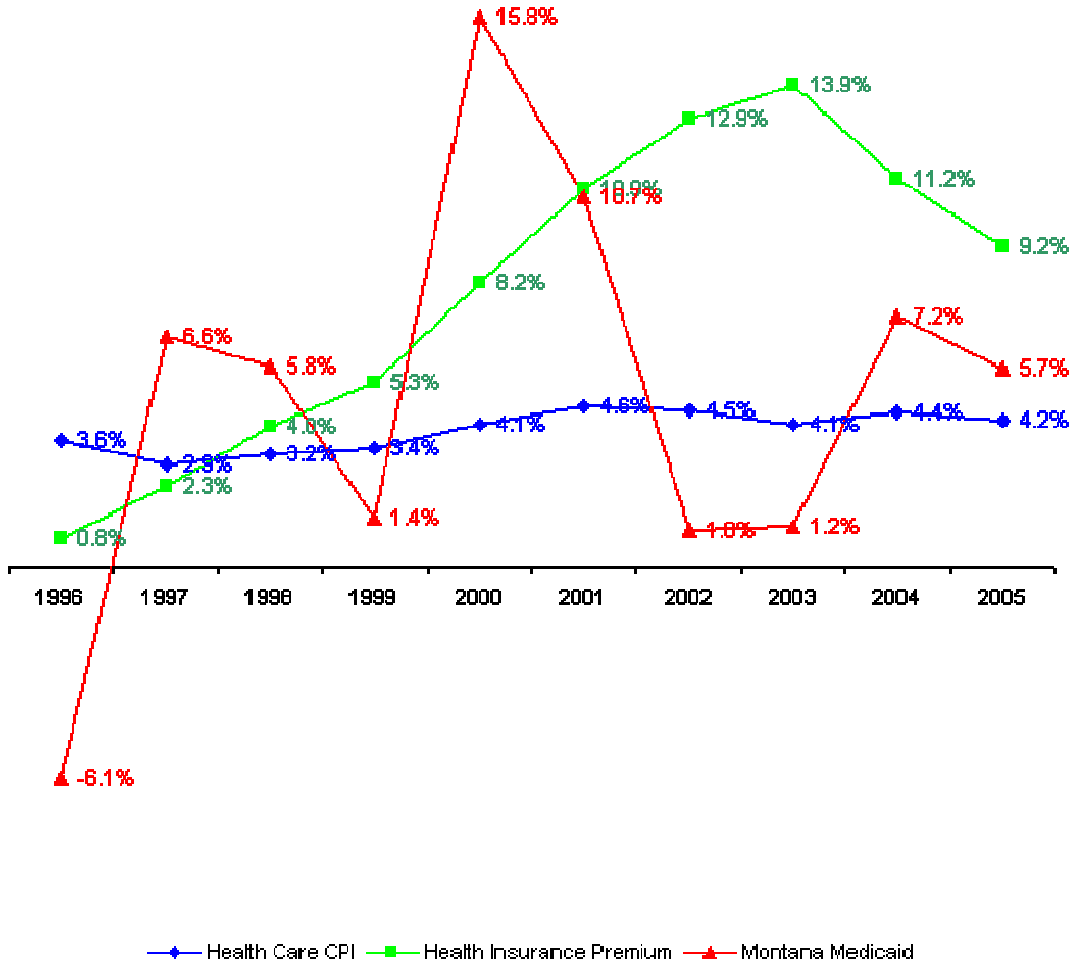






These charts exclude the expenditures and enrollment of CHIP and State Fund Mental Health.

Medicaid Growth Compared to the Health Care Price Index (HCPI) and the Consumer Price Index (CPI) from 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Health Care CPI	3.6%	2.9%	3.2%	3.4%	4.1%	4.6%	4.5%	4.1%	4.4%	4.2%
Health Insurance Premium	0.8%	2.3%	4.0%	5.3%	8.2%	10.9%	12.9%	13.9%	11.2%	9.2%
Montana Medicaid	-6.1%	6.6%	5.8%	1.4%	15.8%	10.7%	1.0%	1.2%	7.2%	5.7%

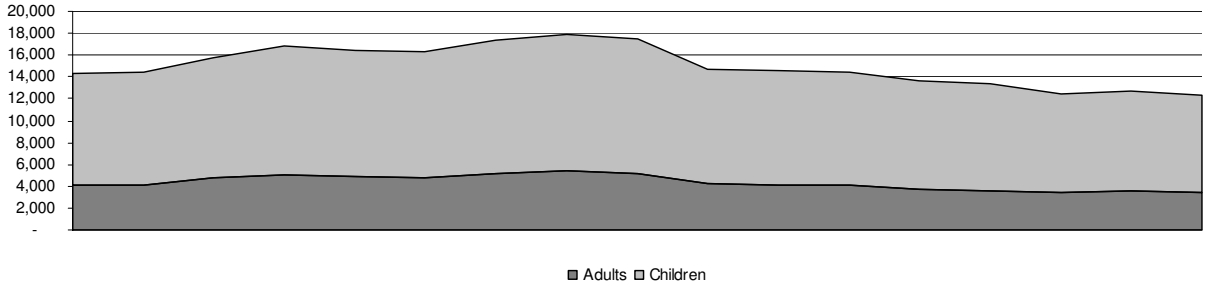
Health Care CPI from US Department of Labor 1982-1984 base year.

Montana Medicaid is based on the per enrollee per month cost increases.

All Medicaid Eligibles, 2001-2005

	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05
Total	73,162	73,058	74,728	76,994	77,420	76,990	78,670	80,179	80,424	80,211	81,466	83,044	83,621	83,286	83,157	84,108	83,858
Adults	32,159	32,150	32,792	33,598	33,752	33,427	33,709	33,931	33,837	33,629	33,970	34,326	34,494	34,395	34,317	34,627	34,508
Children	41,003	40,908	41,936	43,396	43,668	43,563	44,961	46,248	46,587	46,582	47,496	48,718	49,127	48,891	48,840	49,481	49,350

TANF/Medicaid Eligibles, 2001-2005

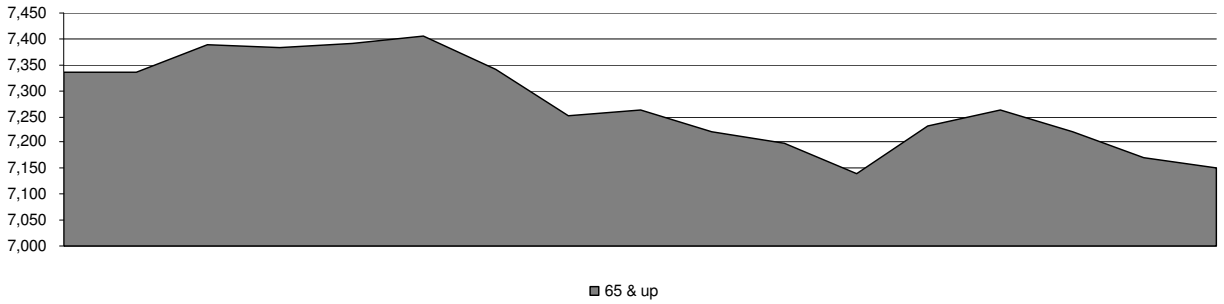


	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05
Total	14,300	14,474	15,773	16,829	16,473	16,237	17,382	17,945	17,526	14,677	14,513	14,411	13,596	13,337	12,428	12,705	12,328
Adults	4,064	4,149	4,711	5,049	4,865	4,814	5,215	5,380	5,131	4,188	4,153	4,102	3,734	3,572	3,410	3,550	3,399
Children	10,236	10,325	11,062	11,780	11,608	11,423	12,167	12,565	12,395	10,489	10,360	10,309	9,862	9,765	9,018	9,155	8,929

Disabled/Medicaid Eligibles, 2001-2005

	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05
Total	15,950	16,106	16,270	16,482	16,558	16,545	16,711	16,759	16,798	16,881	16,987	17,114	17,180	17,322	17,462	17,607	17,607
Adults	13,408	13,538	13,659	13,898	13,975	13,960	14,085	14,121	14,169	14,239	14,354	14,442	14,489	14,600	14,678	14,796	14,821
Children	2,542	2,568	2,611	2,584	2,583	2,585	2,626	2,638	2,629	2,642	2,633	2,672	2,691	2,722	2,784	2,811	2,786

Aged/Medicaid Eligibles, 2001-2005



	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03	Sep-03	Dec-04	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05
65 & up	7,335	7,335	7,389	7,383	7,390	7,404	7,341	7,251	7,263	7,222	7,199	7,139	7,233	7,264	7,221	7,170	7,152

COST CONTAINMENT

The Medicaid Program continues to develop cost containment measures that would enhance the cost effectiveness and efficiency of the program. Some examples include:

School Based Services:

- The Office of Public Instruction certifies the match for the general fund portion for Medicaid reimbursed health-related services written into the Children's Individualized Education Plans.

Nurse First:

- Nurse Advice Line – Toll Free and Confidential Nurse Line that triages caller's symptoms and guides callers to seek care at the appropriate level of care.
- Disease Management – Eligible Medicaid clients diagnosed with asthma, diabetes, and chronic heart failure receive individualized counseling and education that empowers them to be more active in managing their health care. Results are decreased exacerbations and Medicaid expenditures, and improved patient quality of life.
- Team Care – Utilization control through education and restriction. Clients with a history of using Medicaid services at an amount or frequency that is not medically necessary are mandated to participate in the program. Team Care clients are managed by a Team consisting of a PASSPORT primary care provider, one pharmacy, the Nurse First Advice Line, and DPHHS. In January 2006, the enrollment capacity of Team Care doubled to 600 clients.
- Patient Registry – Clinical value metrics and utilization patterns for PASSPORT clients are forwarded to providers; these reports are a tool aimed to assist providers managing clients.

PASSPORT Primary Care Case Management Program:

- PASSPORT was implemented in 1993, with most Medicaid clients required to participate. In PASSPORT, clients must choose one primary care provider who then performs or provides referrals for almost all of the client's care. PASSPORT cost avoids over $20 million per year in medical costs and improves quality of care. Periodic surveys show that over 80% of both providers and clients are satisfied with PASSPORT.

Out-of-State Inpatient & Outpatient Hospital:

- Prior authorization: a mandatory advance approval for all inpatient hospital services out-of-state. Encourage the utilization of available health resources in-state.

Senior and Long Term Care:

- Effective February 8, 2006 the look-back period for transferring assets for less than fair market value in order to qualify for nursing home care was extended from three years to five years with transfer penalties starting when the individual is in a nursing home, applies for Medicaid and is otherwise eligible for Medicaid, rather than the month of the asset transfer.

- Effective July 1, 2005 and 2006 Nursing Facility provider taxes were increased to provide additional funding for Nursing Facilities during the 2007 biennium.

- Beginning in July of 2000 instituted a standardized prior authorization for personal assistance services process, which stabilized growth and reduced expenditures.

- Beginning in January of 2001 this program utilized additional funds in the form of an intergovernmental fund transfer for counties to provide additional payments to at risk nursing facilities.

- Effective July 1, 2001 a new price based reimbursement methodology was adopted for reimbursement of nursing facilities in the state.

Contracts to provide services:

- A contract with Mountain Pacific Quality Health Foundation to assist with transportation services.

- A contract with Walman Optical to provide eyeglass services.

Pharmacy:

- Prior Authorization: A mandatory advance approval of certain drugs before they are dispensed for any medically accepted indication.

- Drug Utilization Review: Prospective & Retrospective review of drug use.

- Over-the-counter drug coverage: When prescribed by a physician a cost effective alternative to higher priced federal legend drugs.

- Mandatory generic substitution: Requires pharmacies to dispense the generic form of the drug.

- Other permissible restrictions – minimum or maximum quantities per prescription or number of refills.

- Preferred Drug List and supplemental rebates: Medicaid's Drug Utilization Review Board/Formulary committee selects drugs in various classes of medications. Extensive review of the medications by the Board yields drugs that represent the best value to the Medicaid program. Many of the preferred drugs also provide supplemental rebates above what is currently offered to the Medicaid program.

Drug Rebate Collection:

The Department has 2 FTEs dedicated to the rebate program and the use of Drug Rebate Analysis and Management System (DRAMS). The staff conducts claim audits and invoice audits prior to invoicing pharmaceutical manufacturers. These duties assure more accurate invoices to the manufacturers and eliminate or reduce disputes with the manufacturers. This assures more timely payments from the manufacturers. Drug rebates continue to average approximately 20% of the Medicaid pharmacy expenditures. The Department has also contracted with Affiliated Computer Services (ACS) to collect rebates on selected physician administered drugs.

CHRONOLOGY OF MAJOR EVENTS IN MONTANA MEDICAID

2006 - Medicare Modernization Act implemented the Medicare Part D drug program that applied to approximately 16,000 Montanans who were eligible for both Medicare and Medicaid (dual eligibles). With the implementation of the Act, the dual eligibles will no longer receive prescription drug coverage through Medicaid, instead their prescription drugs are covered by a Medicare Part D plan**.** The Department is mandated to pay a portion of the drug cost through a Phased-Down Contribution (clawback) for dual eligible clients enrolled in Medicare Part D. Medicaid continues to cover barbiturates, benzodiazepines, smoking cessation drugs, prescription vitamins and the over-the-counter drugs for the dual eligibles as allowed in the Medicaid program.

2006 - The amount of assets a family can have and still qualify for children's Medicaid increased from $3,000 to $15,000 as a result of 2005 Montana Legislative action. Families must continue to meet income requirements to be eligible for children's Medicaid.

2006 - The most recent amendment to the Developmentally Disabled Waiver occurred. The waiver serves people with significant support needs and the amendment expanded service options to include adult foster support, community transition services, adult companionship, assisted living and residential training support.

2006 – The Health Insurance Flexibility and Accountability (HIFA) waiver was submitted to the Centers for Medicare and Medicaid Services (CMS). The Waiver is intended to create a mechanism for Medicaid to pay for services that have historically been funded entirely with state dollars. This will allow the freed up state dollars to leverage additional Medicaid federal dollars.

2006 – The Deficit Reduction Act of 2005 (DRA) mandated certain Medicaid eligibility changes for people who are going to be institutionalized, reside in a nursing home or who are on a waiting list for a Waiver opening. The DRA eligibility changes include increasing the penalty look-back period from three years to five years for nursing home benefits for individuals who transfer assets at less than fair market value, with the look-back period changed to begin when the individual becomes eligible for Medicaid; new citizenship and identity verification requirements of applications for Medicaid; annuities owned by an ineligible or community spouse are considered countable resources for Medicaid applicants; the unpaid balance of a promissory note is considered a countable resource for Medicaid applicants; and the establishment of a $500,000 home equity exclusion limit for long term care applicants/recipients.

2006 – Direct care worker wage increase of $1.00 per hour for nursing facilities and community service providers were implemented utilizing I-149 funding.

2006 – Implemented a 3% provider rate increase to nursing facilities and community service providers utilizing I-149 funding.

2006 – Nursing facility provider tax was increased by $1.75 from $5.30 to $7.05 to fund nursing facility provider rates and services.

2005 - As a result of the Montana Health Care Redesign Project the 2005 Montana Legislature authorized DPHHS to revise the asset test used to determine children's eligibility for Medicaid and the submission of a Health Insurance Flexibility and Accountability (HIFA) Waiver.

2005 - Montana joined the National Medicaid Pooling Initiative (NMPI) in implementing a Preferred Drug List (PDL). The pooling initiative included seven other states: Nevada, Michigan, Vermont, New Hampshire, Alaska, Minnesota and Hawaii and will be implemented through a contract with First Health Services Corporation (FHSC). Under the initiative, the state Medicaid program will create a list of preferred medications in 50 classes of drugs. Preferred drugs are chosen based on their clinical efficiency by a committee of Montana physicians and pharmacists and by the Department based on cost savings. By contracting with FHSC, Montana was able to combine our 80,000 covered lives with covered lives of the other NMPI states resulting in over 3,000,000 covered lives which allow our contractor to negotiate lower discounts with Pharmaceutical Manufacturers.

2005 - The first five year renewal of the Developmental Disabilities Community Supports Waiver occurred. The waiver offers a number of innovative and flexible service options for persons with limited support needs.

2005 - Hurricane survivors who came to Montana after being displaced could apply for access to Medicaid benefits. In cooperation with the federal government, flexibility was provided in meeting the eligibility requirements they normally would have had to meet to apply for and receive benefits.

2005 – Nursing facility provider tax was increased from $4.50 to $5.30 to fund nursing facility provider rates.

2004 - Team Care program was implemented to targeted to people who over-use the Medicaid system. The program requires a group of identified Medicaid clients to enroll in the program and choose one primary care provider and one pharmacy to manage their health care. Clients will receive the professional care they need and have a team to help them decide how and when to access care.

2004 - Montana Health Care Redesign Project Report was published. The Project resulted from 2003 Montana Legislative action and was intended to examine the various options for redesigning the Montana Medicaid program. The Report was provided to the 2005 Legislature outlining the options that could be undertaken to redesign the identified health programs in a fashion that was financially sustainable into the future.

2004 – Nurse First Care Management program was implemented to reduce ineffective use of medical services. Key components are a Nurse Advice Line for most individuals on Medicaid and a Disease Management program for those with chronic conditions such as asthma, diabetes and congestive heart failure.

2004 – FAIM Basic Medicaid waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under - Sections 1925 or 1931 of the Social Security Act.

2004 - Hospital tax was implemented. This change provided increased reimbursement to hospitals using a state tax on hospitals matched with federal Medicaid dollars.

2004 – Nursing facility provider tax increased from $2.80 to $4.50 to fund nursing facility provider rates.

2003 – Children's Mental Health Bureau was created in the Health Resources Division.

2003 – Eliminated coverage of gastric bypass surgery and routine circumcisions at the recommendation of the Medicaid Coverage Review Panel composed of Montana physicians.

2003 – Child and Family Services Division began billing Medicaid for targeted case management services provided to children at risk of abuse and neglect.

2003 – Outpatient reimbursement methodology was changed to Ambulatory Payment Classification (APC).

2003 – On January 10, 2003 implemented a 7% net pay reduction to providers (sunset June 30, 2003).

2003 – On February 1, 2003 reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system (sunset June 30, 2003).

2003 – On August 1, 2003, reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system. Changed all interim reimbursement rates for cost-based facilities to the hospital specific cost to charge ratio.

2002 – Increase Cost Sharing requirements for which the Medicaid eligible persons are responsible.

2002 – Began covering outpatient chemical dependency for adults.

2002 – Implemented a 2.6% net pay reduction to providers (sunset June 30, 2002).

2002 – Implemented reimbursement reductions to hospital inpatient services by reducing the base rates, decreasing the DRG weights by 2%, and eliminating the additional catastrophic case payment.

2002 – July 1, 2001 moved to a case mix price-based system of reimbursement for nursing facility providers.

2001 – Implemented a mandatory generic substitutive policy for pharmaceuticals in the outpatient drug program.

2001 - The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment program for low income uninsured women with breast or cervical cancer diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

2001 – Implemented new reimbursement methodology for Ambulance & Dental Services. Included an 18% increase in funding for the dental program.

2000 – Medicaid HMO program was discontinued due to low penetration and high administrative expenses.

2000 – Nursing Facility Intergovernmental Transfers are implemented to save state general fund.

2000 – Hospital Intergovernmental Transfers are implemented.

2000 – Prior Authorization was required in Personal Assistance Services.

1999 – Mental Health Managed Care abandoned per legislative requirement.

1999 - Ambulatory Surgical Center provider reimbursement was restructured to align with Medicare reimbursement methodologies.

1998 – Area Agencies on Aging converted state general fund to buy slots to expand Waiver.

1997 - New MMIS contract was instituted with Consultec as the fiscal agent (Consultec later changed it's name to Affiliated Computer Services – ACS).

1997 – Resource Based Relative Value System (RBRVS) was implemented to reimburse Physicians, Mid-Level Practitioners and Therapies.

1997 - Mental Health Managed Care was implemented. This program institutes a full-risk, capitated managed care contract for all mental health services statewide.

1997 – Prior authorization was required of Home Health Agency services.

1996 – Federal welfare reform was passed on August 22, 1996. Under the Personal Responsibility and Work Opportunities Reconciliation Act, Medicaid was "de-linked" from AFDC/TANF and began operating without regard to eligibility for cash assistance.

1996 - Departmental reorganization was implemented. Reorganization results in a decentralization of Medicaid; services are managed in divisions primarily responsible for services to specific populations. For example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.

1996 - New outpatient prospective payment system was introduced. The system uses Day Procedure Groups (DPGs) to bundle services at one basic rate.

1995 - Liens and Estates Recovery Program was implemented by the legislature.

1995 - The Families Achieving Independence in Montana (FAIM), welfare reform waiver, received federal approval. The FAIM program began phasing-in implementation in February 1996. Even though the cash assistance caseload experienced a significant reduction, Medicaid eligibility continued for most of families. Cost savings were due to the reduced package of services under FAIM Basic Medicaid, not because of decreased caseloads.

1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMOs exist.

1993 - Passport to Health program was implemented. The program assigns a primary care case manager provider to each participating Medicaid enrollee as a health care manager and gatekeeper of services. The program has yielded significant savings in subsequent years and maintained quality of care.

1993 - New hospital reimbursement system was implemented. The system features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change results in significant savings in subsequent years.

1993 - Out of state hospital initiative was implemented. This program restricts the use of higher cost out of state hospitals when in state hospitals provide the same services. This initiative results in significant savings in subsequent years.

1993 - Medicaid coverage for inpatient psychiatric services was terminated by the legislature

1992 - Federal OBRA 89 increased eligibility for pregnant women and children under age 6 to 133% of the federal poverty level. OBRA 89 stipulates that children are eligible for all medically necessary services.

1992 - Federal OBRA 90 was implemented. A major component of this mandate is to increase eligibility for children aged 6 through 18 to 100% of the federal poverty level. This mandate is being phased in through 2002.

1992 - "Residential Psychiatric Services" was implemented as a Medicaid Service. This service brings rapid increases in cost for the next several years.

1992 - Drug Rebate Program was implemented and began to return a significant portion of prescription drug costs to the state in the form of rebates.

1992 - Formulary and Drug Utilization Review Program was implemented for Medicaid pharmacy services. This program provides significant internal controls and cost savings in subsequent years.

1991 - Nursing home provider tax was implemented. This change increased reimbursement to nursing homes using a state tax on nursing homes matched with federal Medicaid dollars.

1990 - Federal OBRA 87 was implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate affects primarily the nursing home industry and increased Medicaid costs through increased reimbursement to providers. OBRA87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children younger than 6 years.

1988 - "Inpatient Psychiatric Services for Children under age 21" became a Medicaid service. This service increased costs rapidly for the next several years.

1987 - New Hospital reimbursement system was instituted. This Diagnosis Related Group (DRG) system is a prospective rate system.

1985 - New MMIS was instituted with Consultec as the fiscal agent.

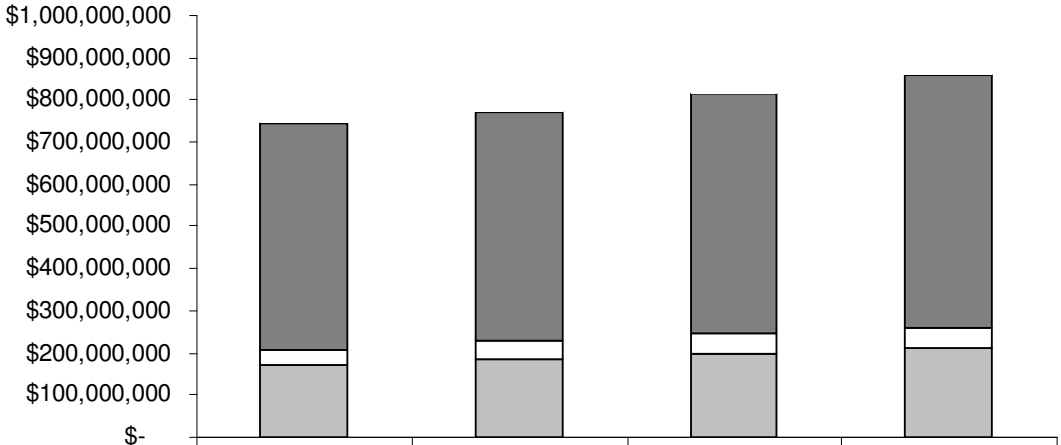
1983 - Department lost Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1) retroactive payments for prior years; 2) increased reimbursement rates for subsequent years.

1982 - The HCBS waiver was implemented. This program consists of multiple services not traditionally offered to Medicaid recipients and designed to help people stay in their own homes rather than moving to an institution.

1982 - Prospective reimbursement system was instituted for the Nursing Home program.

EXPENDITURE PROJECTIONS

Projected State Funds Expenditures in Millions:



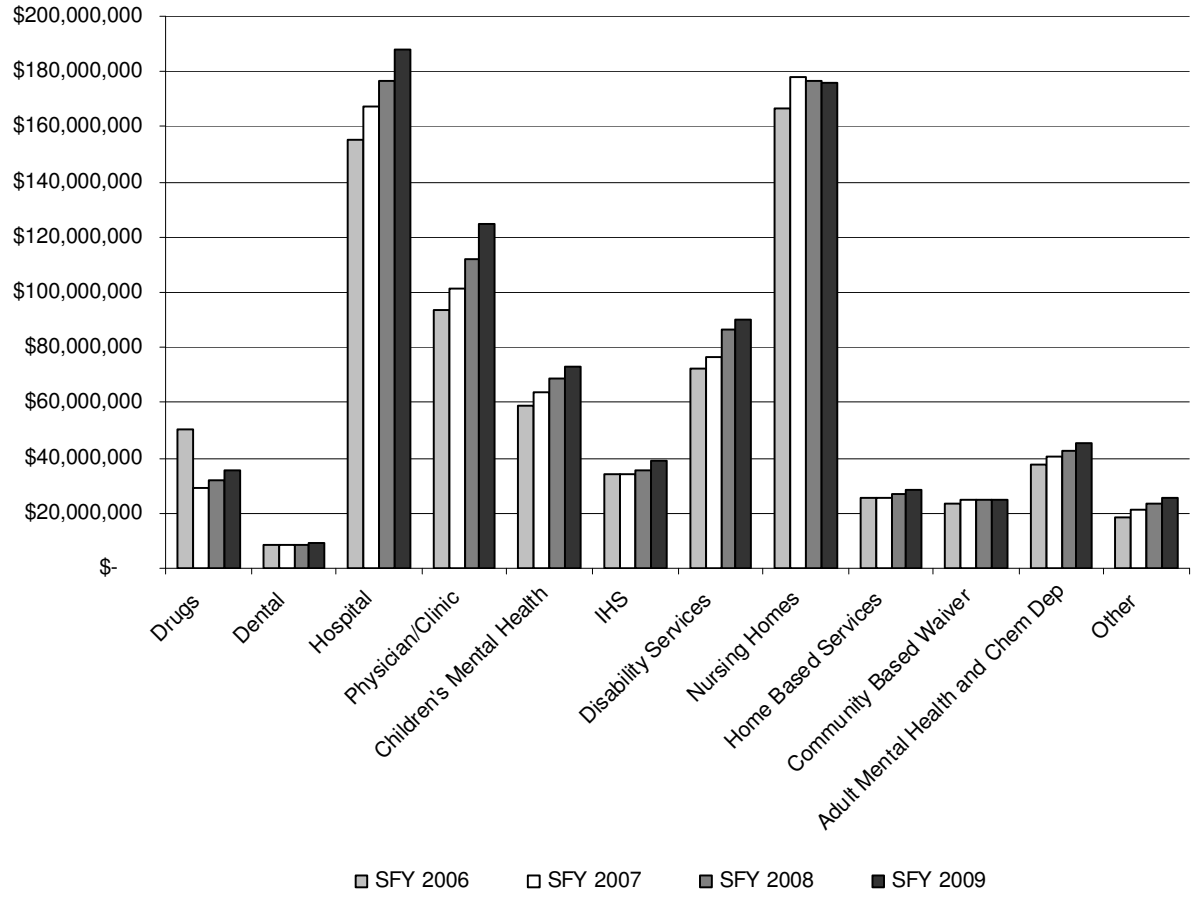
	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Total Projected Expenditures	$745,119,542	$770,585,171	$814,390,696	$860,325,080
Federal Funding	$536,742,784	$541,534,444	$567,222,912	$599,477,573
State Special Revenue	$34,828,047	$44,142,810	$49,761,490	$51,194,773
State General Fund	$173,548,711	$184,907,917	$197,406,294	$209,652,734

State Fiscal Year 2006 is based on projections as of November 2006.

State Funds Percentages of Medicaid

State Fiscal Year	2006	2007	2008	2009
Federal Match Rate	70.66%	69.29%	68.61%	68.51%
State Funds Percentage	29.34%	30.71%	31.39%	31.49%

Projected Expenditures by Provider Type



	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Drugs	50,520,130	29,396,716	32,222,871	35,318,078
Dental	8,383,128	8,294,960	8,834,254	9,335,427
Hospital	155,460,477	167,381,493	176,423,539	188,095,628
Physician/Clinic	93,548,793	101,118,120	112,180,357	125,090,060
Children's Mental Health	58,958,030	64,013,448	68,657,452	73,368,187
IHS	33,881,359	34,000,000	35,349,456	39,075,309
Disability Services	72,619,223	76,330,667	86,624,883	90,221,015
Nursing Homes	166,771,944	177,975,858	176,355,709	175,535,659
Home Based Services	25,683,378	25,843,099	27,018,239	28,531,731
Community Based Waiver	23,159,795	24,870,531	24,870,531	24,870,531
Adult Mental Health and Chem Dep	37,858,409	40,177,458	42,651,874	45,464,328
Other	18,274,876	21,182,821	23,201,531	25,419,127

State Fiscal Year 2006 is based on projections as of November 2006. Prescription expenditures have been reduced by rebates.

GLOSSARY OF ACRONYMS

ACS: Affiliated Computer Services (previously Consultec)

AFDC: Aid to Families with Dependent Children

AMDD: Addictive and Mental Disorders Division

APC: Ambulatory Payment Classification

CAHRD: Child and Adult Health Resources Division (now Health Resources Division)

CD: Chemical Dependency

CFSD: Child and Family Services Division

CHIP: Children's Health Insurance Plan

CMS: Centers for Medicare and Medicaid Services (replaced HCFA)

CPI: Consumer Price Index

DD: Developmental Disabilities

DPGs: Day Procedure Groups

DRAMS: Drug Rebate Analysis and Management System

DRG: Diagnosis Related Group

DSD: Disability Services Division

EFE: Essential For Employment

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

FAIM: Families Achieving Independence in Montana

FFS: Fee-for-Service

FMAP: Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level

FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is Oct 1—Sept 30)

HCFA: Health Care Financing Administration (now Centers for Medicare and Medicaid Services – CMS)

HCBS: Home and Community Based Services

HCPI: Health Care Price Index

HCSD: Human and Community Services Division

HMO: Health Maintenance Organization

HRD: Health Resources Division

ICF/MR: Intermediate Care Facility for Mental Retardation

IHS: Indian Health Services

IMD: Intermediate Care Facility for Mental Disease

MCDC: Montana Chemical Dependency Center

MDC: Montana Developmental Center (ICF/MR)

MH: Mental Health

MHO: Mental Health Organization

MMHNCC: Montana Mental Health Nursing Care Center

MMIS: Medicaid Management Information System

MSH: Montana State Hospital (IMD)

NDC: National Drug Code

NH: Nursing Home

OBRA: Omnibus Budget Reconciliation Act

PAS: Personal Assistance Services

PD: Physically Disabled

QAD: Quality Assurance Division

RBRVS: Resource-Based Relative Value Scale

RHC: Rural Health Clinic

RVU: Relative Value Unit

SAMHSA: Substance Abuse and Mental Health Services Administration

SDMI: Severe and Disabling Mental Illness

SED: Serious Emotional Disturbance (children and adolescents)

SFY: State Fiscal Year (July 1—June 30)

SLTC: Senior and Long Term Care Division

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families